# RENEWAL APPLICATION FOR ACTIVE MEDICAL OR DENTAL STAFF

## COMMONWEALTH OF KENTUCKY
## CABINET FOR HEALTH AND FAMILY SERVICES
## OFFICE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

**To process your renewal application for staff privileges with OCSHCN, please return the following:**

- ☐ Renewal Application for Active Medical or Dental Staff (form OCSHCN-60i), Please sign and date (see last page)
- ☐ Signed Authorization, Attestation, and Release (form OCSHCN-60e)
- ☐ Signed Anti-Harassment and Discrimination Acknowledgment (form OCSHCN-60f)
- ☐ Copy of your current CAQH application
- ☐ Current Curriculum Vitae
- ☐ Copy of current malpractice insurance endorsement
- ☐ Copy of current Kentucky State license
- ☐ Copy of current DEA certificate (if applicable)

For **APRN, in addition to above**, please include:

- ☐ Copy of the Collaborative Practice Agreement with a physician and yourself
- ☐ Copy of your current credentialing from ANCC or the AANP

For **PA, in addition to above**, please include:

- ☐ Copy of the Initial and any Supplemental Application for Physician to Supervise PA
- ☐ Current credentialing from the NCCPA

**PERSONAL INFORMATION:**

Name: (Last) _____ (First) _____ (MI) __

Professional Degree _____ DOB _____

KY State License Number _____ KY Medicaid Number _____

Practice Name _____

Office Address _____
City State Zip Code Country

Office Phone _____ Office Fax_____

Preferred E-mail _____

Office Phone _____ Office Fax _____

**RENEWAL APPLICATION FOR ACTIVE MEDICAL OR DENTAL STAFF**

Preferred E-mail _____

**PEER REFERENCES: Please provide two (2) names of physicians, along with their institution, who have worked closely with you, and can comment on your professional skills.**

Name: (Last) _____ (First) _____ (MI) __

Institution Name_____

Institution Address _____
City State Zip Code Country

Name: (Last) _____ (First) _____ (MI) __

Institution Name_____

Institution Address _____
City State Zip Code Country

**RENEWAL APPLICATION FOR ACTIVE MEDICAL OR DENTAL STAFF**

**Please answer the following questions. For any "Yes" response, give full details on a separate sheet and attach to your application.**

| | | |
|---|---|---|
| 1 | Has your license to practice in any jurisdiction ever been denied, suspended, limited, revoked, or surrendered? | Yes ☐ No ☐ |
| 2 | Has your DEA license ever been denied, suspended, limited, revoked, or surrendered? | Yes ☐ No ☐ |
| 3 | Have you ever been convicted of a felony? | Yes ☐ No ☐ |
| 4 | Have your privileges at any hospital or institution ever been denied, suspended, limited, revoked or not renewed (for other than administrative reasons)? | Yes ☐ No ☐ |
| 5 | Have you ever resigned from a hospital staff or institution while under investigation regarding a breach of professional activity? | Yes ☐ No ☐ |
| 6 | Have you ever been denied membership or a renewal thereof or been subject to disciplinary proceedings in any medical organization? | Yes ☐ No ☐ |
| 7 | Are you now abusing, or have you ever been treated for abuse of, chemical substances? | Yes ☐ No ☐ |
| 8 | Do you carry Medical Liability Insurance in an amount and kind that will insure protection of OCSHCN patients under your care? | Yes ☐ No ☐ |
| 9 | Any claims within past 5 years? | Yes ☐ No ☐ |
| 10 | Are there any pending claims? | Yes ☐ No ☐ |
| 11 | Have you ever had malpractice or liability insurance coverage suspended or denied? | Yes ☐ No ☐ |

## RENEWAL APPLICATION FOR ACTIVE MEDICAL OR DENTAL STAFF

**I certify that all information provided by me in my application is current, true, correct, accurate, and complete to the best of my knowledge and belief, and is furnished in good faith. I certify that I have received a copy of the Medical Staff Policies. In making application for appointment to OCSHCN, I agree to abide by its medical staff's bylaws, rules and policies, to conduct my practice in accordance with high ethical traditions, and I pledge to provide continuous care for all my patients.**

**I further acknowledge and understand that my application does not guarantee that OCSHCN will grant me clinical privileges or contract with me as a provider of service.**

_____

Printed Name

_____ _____

Signature Date